

## Right Care University of Best Practices Meeting – March 7, 2011

### San Diego, CA

Welcome and Introductions – Anthony DeMaria; Facilitator – Anapaum Goel

- There are several Right Care Initiative program levels related to the percentage at which guidelines are being filled. Ultimately, we want our programs to reach a wider population
- Our stated priority: Making San Diego a stroke and heart attack free zone. Our eventual goal, no San Diego citizen will experience a heart attack or stroke.
- We must take a two pronged approach. First, get patients to be screened - Rolf Benirschke. Second, once patients are screened, then we have to have the physicians that see them totally committed to guideline adherence and administer optimal therapy
- Today we want to continue to identify the best ways to organize the people on the medical side so we can be effective in minimizing risk. We also want to learn about how we are incentivizing patients to do things that will be to their benefit in the long run. Mostly, we come here today to listen and learn – so that we can be more effective in our own practices.

Robert Smith – San Diego Veterans Administration IT

- Introduction by Dr. Goel: Dr. Smith has been instrumental in translating clinic practice and marrying it with information technologies (IT). His efforts have helped move the needle at the VA. He is a visionary in how practices can be delivered and how IT can help support that.
- Dr. Smith has been involved in health informatics for about 15 years at the VA
- VA versus HEDIS data at national and SD level. Overall, the VA does extremely well. He plans to use this HEDI performance data as a springboard for showing how they got there.
- LDL control and HbA1c control – 87% is great! Best in the nation. Diabetic BP control 79%. Very good results and national and local level. These tools have been in use nationally and locally.
- 2007 – Health Care Analysis – Implement EMR and use them to improve care. It's very important to provide feedback to providers.
- We would like to emphasize the practices that have brought us to this point.
- VISTA system is the integrated EMR implemented since the late 90s. Usage results very impressive. Single forum for all record keeping – no paper records anymore. Patient centric application.
- Description of the milestones in the San Diego VA between 1999 and 2011. (see slide) System is now widely implemented across systems and through several patient contact modes.
- Screenshots of patient information and system interface (see slides)
- Clinical reminders – logic modules – patient-centric and disease specific. Triggered by lab values. Problem lists and order sheets.
- Dr. DeMaria asked about prompts for reminders. Dr. Smith underscored the importance of looping these reminders back to performance evaluation.
- Automated order entry is a good sustainable method. Leads to many benefits and patient safety features. Care notes also well integrated and searchable.

- Physicians can customize the notes and layouts, but they have learned that most physicians don't really have the time to do that. Unstructured menus and open fields led to longer time for adoption and use.
- Dr. Fremont asked about expert users or go-to gurus on the system. Dr. Smith responds - Yes, there are champions that were given a little higher access and people could identify themselves as clinical champions.
- Prompts for orders.
- Hattie Hanley asked if they can track stroke rates occurring since they have been performing well on target measures? Dr. Smith answers - So far, no, the system isn't designed to track these rates following adherence to the HEDIS measures.
- Point-of-Care reminders very helpful in influencing physician behavior. Reports available to verify diagnoses, identify patients etc. Data can be aggregated at facility or national level.
- Dr. Yphantides asks about incentives at provider, facility and higher levels. Dr. Smith says - Yes, there are incentives at multiple levels. For example, they built in reminders for HIV testing that started local and then went nationwide. Just implementing the reminders helped increase compliance.
- Dr. Dudl comments on reminders - sometimes they work, sometimes not as well. Needs to be done at point-of-care and there needs to be a report card and it needs to be tied to something important to that person receiving the report card. Dr. Fremont added - They are necessary but not sufficient. Specialist versus primary care physicians might find them more or less helpful.
- Current targets on deck include: PCMH Patient aligned care teams, Chronic Disease Management using Telehealth, Health promotion and Disease Prevention
- Dr. Goel asked about what to do if physicians say they have "special" patients. Dr. Smith answers - For "exception" patients - process and outcome reminders exist in the system. Physicians do get "credit" for some of the process reminders but not for some of the outcome measures for the "exception" patients. They used to give credit for both, but that had to change because they weren't able to reach outcome targets well.
- Dr. Bayne - Have you looked at the results of the 30,000 home-based primary care patients versus the general population sector. Dr. Smith responded that the answer is related to the question Hattie had regarding how closely they can track the performance of these outcomes. They haven't gotten to fully tracking the performance for these specific groups.

#### Mary Kodiath - Health Promotion Disease Prevention at The SD VA

- Mary left Sharp and went to the VA 25 years ago.
- She wants to talk about how Health Promotion Disease Prevention (HPDP) has been able to receive clinical interventions in a "seamless integrated continuum of health care" and how VHA clinicians and staff are proud of the program.
- She walks us through an example of how a patient might encounter the system and how they get multiple touches with the HPDP program.
- Many of the innovations include simple things like asking the patient himself, "What have you been doing to improve your health?" So simple and yet the staff thought it was so great. But

why? Because the patients actually had answers! And they were answers that fit with what the patients perceived as positive change for their health. A lot of times we just “tell patients” what to do rather than “ask” them.

- The LVN and RN Care Managers are very important allied health providers that know the system. It is important they feel empowered in their roles.
- Wellness Clinic – a drop-in group in Oceanside – you can come by and have an hour-long clinic. They try it out and see how well it goes and then if it takes off then maybe they’ll spread to other clinics. The patients know what they want and what they are willing to do, etc.
- Motivational Interviewing (MI) – started in mental health and substance abuse fields. The idea is to meet the patient where the patient is “at.” It is a way to help patients at the point they are ready for. Try to get primary care providers to get this MI training. The point is not to do “MORE” it’s just to do things DIFFERENTLY!
- Stanford CDSMP – Transformational program. Training patients to self-manage their own chronic illness. And soon the patients will teach other patients to manage their own chronic illness.
- Behind the Scene – Key people to keep the HPDP program running. Monthly measures and metrics. Also, they have monthly check-ins.

#### Introductions from the Group

#### Large Group Discussion

- Dr. Goel starts the discussion by saying he wants to discuss a few larger issues that came up: 1) Leadership and buy-in. 2) Transparency about where we stand in relation to others when sharing data. 3) Developing group benefits for reaching targets and incentivizing to reach those targets. He asks: How hard would it be to come together to trust each other to share data to get some group targets together and then move it to a community wide target?
- Dr. DeMaria asks is it important to have the financial incentive. Dr. Smith says he thinks it helps but it’s not necessary. The notion of being held accountable with the feedback is enough.
- Dr. Goel posits some docs say why should I as a physician participate with the data sharing.
- Dr. Farrell offers that we need to make sure if we “share” data that it is “good” and that we collect it correctly.
- Dr. Goel says – yes – we need to be able to “own” your information – not even just for public reporting, but we are talking about within this small group reporting and sharing too.
- Dr. Nick Yphantides offers that SD is a very unusual environment with special challenges and organizational benefits and issues. If we are too “organizationally” focused, we run the risk of increasing the health disparities and increasing the gap between the “haves” and the “have nots.”
- Hattie Hanley offers when the University of Best Practices was originally conceived we thought it should be open to every med system in SD. Those around this table represent about 95% of the population of SD. This forum is about seeing if those around this table can reduce heart attacks and stroke by 50% in the next 5 years. Is that not a realistic target?

- Dr. Goel asks about the notion of getting leadership commitment. Dr. Smith agrees performance measurement and monitoring is so important.
- Dr. Fremont asks about VA patients who see providers outside the VA or if some patients are seen by multiple plans. What about difficulties because people end up moving from plan to plan or provider to provider.
- Dr. Dudl suggests that since we have Dr. Boganey (Kaiser) and Dr. Smith (VA) here, we already have the beginnings of a central seed for some sharing to start occurring.
- Dr. Fremont adds that most of the data out there is not granular, aggregated and often not actionable.
- Dr. Goel wrapped up the session with some questions for the group to think about on whether this is truly possible to come together, have this group share data, etc. We will reconvene in a month to continue to work on these issues.

Notes prepared by Deborah Ling Grant, Comparative Effectiveness and Outcomes Improvement Center